OHS/CAD-200 (7/03)

Instructions

Print legibly or type information. Sign at bottom.
Complete ***all*** sections of this form.
Return white copy to the address at right.
Retain canary copy for your records.

State of Michigan
Department of Consumer & Industry Services
Bureau of Health Services
Complaint and Allegation Division
P.O. Box 30670
Lansing, Michigan 48909-8170
http://www.michigan.gov/bhser/

Office Use Only

File #

ALLEGATION FORM

Authority: P.A. 368 of 1978, as amended.
Completion: Voluntary Penalty: None

I wish to complain against the individual named below. **I understand that this agency and the Licensing Board do not assist citizens seeking return of their money or other personal remedies.** I am, however, submitting this information so that it may be determined if licensing action against this practitioner should be considered.

Information About You			Complaint Filed Against	
Your Name			Practitioner's Name	
Street Address			Street Address	
City			City	
State	ZIP Code	County	State	ZIP Code
Patient's Name			Practitioner's Telephone Number ( )	
Your Telephone Number Home: ( ) Work: ( )			Treatment/Incident Date	

Check One:

☐ Allopathic Physician (MD)	☐ Emergency Medical Services Personnel	☐ Nursing Home Administrator	☐ Pharmacist	☐ Psychologist
☐ Chiropractor	☐ Marriage & Family Therapist	☐ Occupational Therapist	☐ Physician's Assistant	☐ Sanitarian
☐ Counselor	☐ Nurse (LPN or RN)	☐ Optometrist	☐ Physical Therapist	☐ Social Worker
☐ Dentist	☐ Nurse Aide (CENA)	☐ Osteopathic Physician (DO)	☐ Podiatrist	☐ Veterinarian

Is there court action pending?	Enter Your Attorney's Name	May we release your name and this information to the practitioner?	Will you testify at an Administrative Hearing if necessary?
☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Give details of your concerns (who, what, when, where, how, etc. Use additional sheets if necessary).

Signature _____ Date _____